Chapter 6
Steps Towards Developing a Texas Health Workforce Plan

Goal 1:	Ensure that the needed number of health care professionals are educated and trained.

Objective 1.1 Conduct workforce supply and requirements planning for Texas 2000-2030.

Background

Under the general parameters of Chapters 104 and 105 of the Health and Safety Code, the Statewide Health Coordinating Council is directed to do the following:

- Establish a comprehensive health profession resource center for the collection and analysis of education and employment trends.
- Collect and disseminate data on health professions demonstrating an acute shortage in the state.
- Develop uniform standards for health professional data.
- Monitor and develop local, regional, and statewide needs.
- Develop workforce goals and recommend appropriate level of funding.

In the past, workforce planning has focused almost exclusively on physicians, with little study of the other health care professionals who make up the health care workforce. Recently, attention has been focused on primary care physicians and nonphysician primary care providers. Integration of the delivery of care across the entire spectrum of primary care providers is proposed as a method of meeting the requirements of access, quality, and cost containment. Definitions of primary health care vary, but state and federal statutes usually include the specialties of family medical practice, general internal medicine, general pediatrics and obstetrics-gynecology. Texas uses the above definition. The April 1994, *Journal of General Internal Medicine,* recommends adding the following to the specialties above: advanced nurse practitioners, nurse midwives, and physician assistants.[1]

Effective workforce planning is long-range and should project needs based on demographic trends,

health trends, provider mix, insurance coverage, and changes in health care delivery systems. This is the charge of the Health Professions Resource Center. Based upon a preliminary evaluation of health professions data bases conducted by the Health Professions Resource Center, it appears that Texas licensing boards do not consistently collect, store, format, or present data in ways that are conducive to effective workforce analyses and planning (See Table 1).

In the interest of good workforce planning and statistics gathering, reliable data in multiple formats and media must be available and accessible to in-state and out-of- state customers. Guidelines that can be used by workforce planners in collaboration with health professions boards include developing minimum standards for licensure data sets, standardizing terms, maintaining historical data bases, and the annual renewal of licenses. These guidelines are described below.

Develop a Minimum Uniform Health Professions Data Set

Certain types of data are critical to the licensure and certification programs for health professionals. Also, certain types of data are critical to statistical analyses and reports about health professionals. Although many boards publish summary data concerning their health professions, these reports do not always coincide with the statistical needs of workforce planners. Thus, by establishing a minimum data set for all health care professions, the informational requirements of licensure boards, licensees, professional organizations, community groups, state planners and legislators can be met. In addition, by establishing a minimum data base, the requirement for sharing of data bases among other states and the federal government can best be satisfied. A few of the licensure data problems that the Health Professions Resource Center has identified are listed in Table 1.

Standardize Health Care Professions Terms

Use of standard terms enhances the compatibility of health professions data from a variety of sources and from other states. States that have developed standardized terms, abbreviations, collection methods, data entry and validation procedures, and storage formats and media have described these as being basic requirements for assessing workforce data, preparing demographic reports, conducting health professions studies, and sharing data among organizations and agencies.[2] This focus on standardization is for the purpose of being customer-friendly and is especially important in forecasting requirements for health professionals and advising legislators or community officials on matters concerning the health professions.

Table 6-1: Examples of Texas Health Professions Database Problems

Type of Licensure Data Problem	Problem Adversely Affects the Following
Incomplete or missing data	**Summary information and trend analyses**, e.g., number of female providers per county and the number of nurses in TX from 1991-1998. Incorrect abbreviations in fields creates inaccurate sorting of data, e.g., "T", "TZ", "TA" and "A" for TX.
Mixed data types and duplicate licensure records	**Summary information.** Some boards have mixed types of data in their licensure data bases. For example, one board allows one professional to be licensed for two closely associated professions and his or her licensure data entered as two records in the same data base. Another board allows for the licensure of both businesses and professionals as records in the data base. The professional may be licensed under either the business' license or the professional's license.
Missing practice hours	**Calculations of Full-Time-Equivalent (FTE) ratios for geographic areas.** Required for the Federal Health Professional Shortage Area (HPSA) program and other programs.
Practice address incorrect or missing	**Practice Location.** Distribution of practitioners by geographic area may be affected. Some boards use the mailing (or corresponding) address for the county field. Addresses with street names, numbers and zip codes allow for geocoding to county and census tract-level of analysis, especially important for zip codes that cross county lines. Most post office box numbers and facility names for street addresses do not geocode.
One practice address (with or without a mailing address)	**Provider distribution tables** (by county, ZIP code, etc.) may be inaccurate for practitioners who live in one county but provide care in adjacent counties. One primary and one secondary site, each with listed practice hours, would alleviate this inaccuracy.
County name or code incorrect	**Provider distribution by geographic area** cannot be accurately assessed if county name or code is incorrect. This will affect the accuracy of the supply data.
Use of "not in practice" and other terms in address fields	**Supply data** will be inaccurate is there is not the assignment of codes to the provider's record that indicates "not in practice," thereby allowing for the removal of these providers with a data base command function.

Maintain Historical Data Bases

Since most Texas licensure boards maintain only periodic paper copies of summarized licensure data and not computer-based data base files, the Health Professions Resources Center is one of the few repositories for health professions-related data in Texas. Efforts are under way at the center to convert historical tape licensure files into easily accessed data base files. Computer files of historical

data are very important to states and health professions data centers because it allows for the comparing of trends and issues over time.

Renew Board Licenses on an Annual Basis

Some Texas licensure boards renew licenses biennially. Although this may be a cost savings to the boards, the loss of annual practitioner supply data adversely affects studies concerning trends, the distribution of health professionals, population-to-provider ratios, and other health professions-related statistics. Although biennial renewals with annual mailings from the board to licensees asking for any changes in address and other licensure information would be acceptable for annual data base updates and statistical purposes, unless requests for changes are linked to the license-renewal process, compliance with these requests has been found to be less than satisfactory.

Annual licensure data updates best serve workforce planning since it is well demonstrated by practitioner survey work done at the Health Professions Resource Center that a large proportion of providers move within any calendar year to new practice sites. Biennial updates would not allow for adequate detection of these changes.

Strategy 1.1.1

The Statewide Health Coordinating Council appoints a Health Personnel Data Advisory Committee to work with the Health Professions Resource Center to improve coordination of data collection and statewide planning efforts. This advisory committee is charged with providing technical expertise in the following areas:

1) Coordination and integration of data collection efforts of state agencies, industry, and professional associations;
2) Standardization of terminology and definitions used in health professions data;
3) Exploration of ways to establish electronic data sharing; and
4) Guidance in data collection and analysis activities and promotion of completion of surveys, if developed.

It is recommended that two members of the Statewide Health Coordinating Council serve on this committee and that the committee be led by the Health Professions Resource Center. Other members should include representation from the following groups:

1. Health Professions Council
2. Texas Higher Education Coordinating Board Health Professions staff
3. Medical Education
4. Health Care Information Council
5. Health Care Industry
6. Texas Workforce Commission

Report with recommendations due to the Statewide Health Coordinating Council by January 2000.

Strategy 1.1.2

The Health Professions Resource Center, with assistance from the Health Personnel Data Advisory Committee, will conduct ongoing assessments of the workforce supply of primary care physicians, selected physician specialties, physician assistants, advanced practice nurses, nurse midwives, and identify data sources on other heatlh professions.

Strategy 1.1.3

Based upon workforce supply and requirements analyses completed by the Health Professions Resource Center and the Health Personnel Data Advisory group, the Statewide Health Coordinating Council, in consultation with the Higher Education Coordinating Board and its relevant advisory committees, will make recommendations on programs and funding for health professions education in the State Health Plan Update in 2000.

Goal 2:	Improve health professions regulation to ensure quality health care for Texans.

Objective 2.1 Establish fair and equitable mechanisms and processes that will address health professions regulation.

Background

Health Professions Regulation

The issues related to health professions regulation are controversial and politically charged. The table below was developed by the Maine Health Professions Regulation Project and shows how health professions regulation is evolving.[3]

Table 6-2: Changes in Health Professions Regulation

Current Regulation	Evolving Regulation
Regulate solo practitioners	Continue to regulate individuals as solo practitioners, but recognize the changes in the organization of care
Standards only for entry to practice	Standards for entry to practice and continued competence
Little communication between boards and between health professions	Formal mechanism for assuring communication between boards and activation of interprofessional work groups
Changes in law initiated by individual health professions	Changes in law recommended by a department's commissioner and a federation or interprofessional group
Scope of practice turf battles end up in legislators' laps	Stakeholders along with impartial, knowledgeable health experts evaluate professions' competencies to provide certain health services and advise legislators

Chapter Four of the State Health Plan outlines the major issues related to health professions regulation. It is important that any study of health professions regulation be one that encompasses all of the issues. What is most important for the state is that effective ways of dealing with these issues are designed to provide for input from the stakeholders involved. Regulatory issues need to be discussed in a broader public forum, involve consumers, health professionals, direct-service providers, public health policymakers, and others. This is most important in any discussion of

proposed legislation that deals with scope of practice.

The supply and character of the health care workforce available to meet the demand for health care services at any given time is in part determined by the geographic location of those practitioners. Texas has a demonstrated shortage of providers in 136 whole or partial counties that are designated as Health Professions Shortage Areas in 1998. The HPSA designations are determined by the number of persons served by a primary care physician. While there are concerns about the maldistribution of physician supply and physician types (primary care generalists/specialists), current literature suggests that nonphysician health care providers may supplement the primary care physician workforce and provide more staffing options for rural and underserved areas.[4] It has also been suggested that it may be easier to staff rural and under-served urban areas with this level of provider.[5] The continued proliferation of the use of the nursing and allied health workforce and the use of unlicensed assistive personnel leads to scope of practice questions that must be determined through state legislation. In order for the legislature to make good decisions on these issues, criteria for changing a profession's scope of practice or for licensing a new profession must be established.

Health Professions Education

One of the primary outcomes of health care reform discussions has been the concern about the adequacy and relevance of the health professions curricula and the insistence that it prepare health professionals to meet the public's health care needs. One obvious example of this is the general acceptance of the idea that 50 percent of medical school graduates should become primary care providers. The changes in health care delivery and the public's expectations of health care service providers has led to discussions about health professionals' continuing competency.

The trends that are driving changes in medical education include the focus on outcomes and accountability, primary and preventive care, a consumer/patient orientation, working in multidisciplinary teams, and community responsibility and accountability. These changes have led to a call for physician education that includes more clinical practice, ethics, behavioral medicine, clinical epidemiology, medical economics, working in multidisciplinary teams, and use of technology and information management, as well as the concepts and practice of community based

medicine.[6] Competency identification and curricular reform including continuing professional education for competency are called for in nursing and allied health professions as well as in physician education.

Texas has made significant initial efforts to address continued competency and health professions regulation. The proposed strategies by the Statewide Health Coordinating Council will ensure that Texas is in the forefront in ensuring quality health care.

Strategy 2.1.1

The 76th Texas Legislature appoints a multidisciplinary task force to review and make recommendations on the following issues related to health professions regulation:

1) Composition of health professions boards
2) Complaint and grievance processes
3) Disciplining of members
4) Licensing and re-licensing requirements
5) Reciprocity and credentialing issues
6) Dissemination of information to consumers
7) Requirements for continuing education

Membership of this task force should be drawn from:

1) Health Professions Council
2) Consumers
3) Medical policy and ethics experts
4) Academic health centers
5) Professional medical associations
6) Professional nursing associations
7) Representatives from other health professions
8) Health Professions Resource Center

This Task Force should report to the Legislature and the Statewide Health Coordinating Council by January 2000.

Strategy 2.1.2

The 76th Texas Legislature appoints or creates a body to advise it on scope of practice recommendations. This body should establish criteria for evaluating any request for changes to any professional or occupational group, organization, or individual that proposes regulation of any unregulated professional or occupational group or substantial expansion of regulation of a regulated professional or occupational group. These criteria should address:

1) data on the professional or occupational group,
2) the overall cost effectiveness and economic impact of the proposed regulation,
3) the extent to which the regulation or expansion of regulation of the profession or occupation would increase or decrease the availability of services to the public,
4) documentation of improved or enhanced quality of care, and
5) comparison with existing regulations and findings from other states

Input on these issues and recommendations to the legislature should come from discussion and representation from:

1) Health professionals
2) Academic health centers
3) State agencies
4) Health care industry
5) Consumers

Goal 3:	Address the maldistribution of health professionals.

Objective 3.1 Increase access to health care through technology.

Background

Emerging Technologies

The lack of available qualified health professionals continues to be a major barrier to accessing health care in rural Texas and in some urban areas. Evolving technologies for health care hold promise as strategies for providing greater access to medical care, ensuring quality of care, and containing the costs of medical care through early diagnosis and intervention. Telehealth refers to the use of electronic communications networks for the transmission of information and data for the purposes of health promotion, disease prevention, patient/community education and the linkages of health care resources and referrals.

Telemedicine refers to a professional providing interactive, long-distance services to a consumer in another location. This may be by telephone, facsimile, Internet, still-image transmission (e.g. teleradiololgy) or two-way video/ two-way audio conferencing. A national survey done by the Council on Licensure, Enforcement, and Regulation (CLEAR) revealed that telemedicine is used in the practice fields of medicine; dentistry; counseling; occupational, physical, respiratory, and speech therapies; radiologic technologies; and pharmacology.[7]

The Council on Graduate Medical Education's 10th report titled "Physician Distribution and Health Care Challenges in Rural and Inner-City Areas" states that telemedicine holds:

> ...enormous potential for mitigating the impact of the maldistribution of health professionals. ...By bringing together patients, primary care physicians, and specialists through telecommunications, it is possible to solve complex clinical problems, increase professional collaboration and training, support continuing medical education, and foster network development -- all with reasonable cost.[8]

Texas has a number of very active telemedicine initiatives. Two of those initiatives received

national recognition in the December 1996 and December 1997 issues of *Telemedicine and Telehealth Networks* magazine. Texas Tech University Health Sciences Center's HealthNet, one of the longest running nonmilitary telemedicine programs, was recognized for its caring and committed approach to providing rural health services. The University of Texas Medical Branch at Galveston was recognized for its application of telemedicine in primary and specialty care for prison inmates.[9] Almost every Texas health center has an active telemedicine program. In addition, Texas has the largest public health telemedicine program in the nation. This program, which targets the use of telemedicine for tuberculosis and diabetes, is a partnership with the University of Texas Health Science Center at San Antonio and the Texas Department of Health's South Texas Hospital in Harlingen.

House Bill 2128, passed by the 74th Legislature, established the Telecommunications Infrastructure Fund (TIF). That fund is to be used to further telecommunications technology for K-12, higher education, libraries, and telemedicine. The TIF board released its first requests for telemedicine proposals in the summer of 1998. One request for proposal called for telemedicine projects that focus on providing Internet connectivity for health care facilities in rural areas. The other was for clinical telemedicine demonstration projects that will address specific needs of medically under-served areas.

The Texas Telehealth/Education Consortium, made up of members from academic health centers and other medical education institutions, in collaboration with the TIF board and the Center for Rural Health Initiatives, has conducted two studies of telemedicine in Texas. Those studies have served to identify and raise telemedicine issues in Texas, educate state policymakers, and make recommendations to guide grant funding.[10, 11]

Some of the recommendations are to:

- create a statewide telemedicine network based on an open architecture;
- establish a planning and oversight group;
- track legal and regulatory issues in the areas of licensure and credentialing, reciprocity,

liability and legal jurisdiction, privacy and reimbursement;

- provide for informed consent for consumers; and
- work with medical schools to develop curriculum for health practitioners on the uses of the various telecommunications technologies.

The Texas Telehealth/Education Consortium also sponsored a statewide Telemedicine Conference in April 1998 to identify the best practices in telemedicine and to benchmark the practice of telemedicine in Texas.

The Council on Licensure, Enforcement and Regulation states that the issues related to telemedicine will become more and more political. While the technology has the potential to transform the way segments of the population receive health care, detractors are concerned about the elimination of face-to-face contact, the security of medical information, and the risk of fraud and malpractice.[12] The 10th COGME report recommends that states address the following issues for successful implementation of telemedicine:[13]

- codify, standardize, and evaluate those experimental and practical applications that exist;
- resolve professional licensure regulations, especially the issue of reciprocity, for the practice of medicine across state lines;
- establish clear protocols and a unified technological infrastructure to reduce costs and provide rural practitioners with options for communicating with multiple providers; and
- establish reasonable standards for reimbursement for those providing medical services at a distance.

Given the potential positive benefits of telemedicine for the state, it is important that there be an overall state plan that ensures that the benefits are realized and that the problems associated with the effective implementation of telecommunications technology in the delivery of services are addressed. Important groundwork has been done in the two reports by the Texas Telehealth Education Consortium, the Center for Rural Health Initiatives and the Telecommunications Infrastructure Fund Board. However, larger issues continue to arise and need to be addressed in a collaborative manner.

Another strategy proposed by the Statewide Health Coordinating Council is to coordinate the programs that have responsibility for the recruitment and retention of providers in under-served areas.

Strategy 3.1.1

The governor or 76th Texas Legislature appoints a task force to develop a statewide telemedicine plan that will increase access to medical care, extend the workforce, and enhance workforce training. This plan should:

1) provide guidelines for the Telecommunications Infrastructure Fund on grant funding for telemedicine projects;
2) recommend a telecommunications infrastructure to build and support telemedicine;
3) define the role of medical schools, teaching hospitals and public health clinics.
4) establish priorities/criteria for the funding of telemedicine sites to serve rural and medically underserved areas;
5) define evaluation criteria for telemedicine projects funded by the TIF;
6) include for the provision of education of health professionals in community sites;
7) make policy recommendations to ensure the quality of care and the stability of local health care systems;
8) designate a group to coordinate statewide telemedicine initiatives; and
9) review and make recommendations on interstate licensing issues related to the use of technology.

Membership on this task force should include:

1) Telecommunications Infrastructure Fund Telemedicine Steering Committee
2) Center for Rural Health Initiatives
3) Texas Telehealth/Education Consortium
4) Texas Telecommunications Planning Group
5) Texas Department of Health

6) Academic health centers
7) Area health education centers
8) Texas Higher Education Coordinating Board and its Family Practice Advisory Committee
9) Texas Rural Health Association
10) Texas Organization of Rural and Community Hospitals
11) Texas Academy of Family Physicians

This task force should report recommendations to the Statewide Health Coordinating Council and the governor or 77th Legislature by January 2000.

Objective 3.2 Increase access to health care through the coordination of recruitment and retention activities.

Recruitment and Retention Efforts

The Health Resources and Services Administration, Division of Shortage Designation, is the federal program responsible for determining under-served and shortage areas for a number of health professions. The January 1988 update of the Health Professional Shortage Areas Basic Listing indicated that Texas has 201 counties, service areas, population groups and facilities designated as health professions shortage areas. Designation of such an area provides eligibility for designation-based incentives such as Medicare bonus programs and increased Medicaid reimbursement rates. Despite these efforts, shortages persist and the numbers of areas designated as shortage areas have continued to increase. Currently in Texas, this federal program is the only one used to designate under-served areas. States are not discouraged from implementing a state-level designation of shortage areas. At this time, Texas does not have a comprehensive plan with measures for prioritizing and designating shortage areas outside of the federal designations.

In an effort to increase the number of providers in shortage and under-served areas, a number of federal and state-funded programs exist. The following is a listing of those programs and the agency that has oversight of those activities.

National Health Service Corps - The Texas Department of Health administers through a cooperative agreement with the Health Resources and Services Administration. Federally funded.

J-1 Visa Waiver - U.S. Department of Agriculture. The Texas Department of Health provides information to sites, providers and to the U.S. Department of Agriculture. No funding.

State Loan Repayment Program - Texas Higher Education Coordinating Board with a match grant from the Health Resources and Services Administration. State and federal funds.

Physician Education Loan Repayment Program - Texas Higher Education Coordinating Board. State funded.

Family Practice, Resident, and Faculty Loan Repayments - Texas Higher Education Coordinating Board. State funded.

Rural Physician Assistant Program Loan Repayment Program - Center for Rural Health Initiatives. State funded.

Community Scholarship Program - Center for Rural Health Initiatives. Federal and state and with community match funds.

Texas Outstanding Rural Scholar Recognition Program - Center for Rural Health Initiatives. State with community match funds.

Health Find/Pro Find - Center for Rural Health Initiatives. State funded.

In addition to the above programs, the East Texas and the South Texas Area Health Education Centers (AHECs) also work within their communities to promote health careers and recruit health professionals. In the summer of 1998, the East Texas AHEC received a grant from the Robert Wood Johnson Foundation to help improve access to basic health care in its most rural and medically under-served areas. With so many different programs responsible for the recruitment of health professionals, there is a strong need for those efforts to be coordinated.

Strategy 3.2.1

The Statewide Health Coordinating Council establishes an ad hoc committee to assess the effectiveness of current recruitment and retention efforts of health professionals in rural and underserved areas and recommend ways to improve the coordination of those programs. This committee should:

1) identify practice issues and barriers to recruiting and retaining providers in underserved areas,
2) evaluate the effectiveness of current recruitment and retention efforts in rural and underserved areas,
3) determine strategies for improving access to primary care and ways of measuring performance in this activity, and
4) make recommendations for coordination of activities and/or modifications to programs to increase access to medical care.

Membership on this ad hoc committee should include two Statewide Health Coordinating Council members and:

1) The Texas Department of Health, Primary Care Provider Placement Program
2) The Texas Department of Health, Health Professions Resource Center
3) The Center for Rural Health Initiatives
4) Texas Higher Education Coordinating Board
5) Area health education centers
6) Academic health centers

This ad hoc committee should report to the Statewide Health Coordinating Council by October 1999.

Goal 4:	Create a health care workforce trained and equipped to use education and prevention as the primary approach to helping Texans achieve optimal health.

Objective 4.1 Increase the implementation of prevention activities in the health care community through the academic curriculum.

Background

Preventive Measures

Prevention and wellness strategies are the hallmarks of public health. At the beginning of the 20th century, public health initiatives using sanitation, control of infectious diseases through immunizations, quarantines, and other public health activities contributed much to the benefit of the national health and extended life span. However, until recently, clinical health practices seldom included disease and injury prevention strategies for individuals. In fact, many health clinicians have no contact with their clients except when they are ill or injured.

By putting emphasis on public health strategies such as disease prevention and population-based health measures, health expenditures could be leveraged to save money by reducing the need for expensive treatment methods such as surgery, drugs and hospitalization. Some of the population-based health strategies that protect the public include sanitation, epidemiology, environmental protection, and clean air measures. These strategies are aimed at achieving the goals of public health as delineated by the Institute of Medicine:[14]

- Prevent epidemics and the spread of disease
- Protect against environmental hazards
- Prevent injuries
- Promote and encourage healthy behaviors
- Respond to disasters and assist communities in recovery
- Assure the quality and accessibility of health services

Recognizing that while prevention activities can be a cost-effective long-term method for reducing diseases and disabling accidents and injuries, thereby reducing health care costs as well, preventive health is still a much underutilized tool in most clinical environments. Many patients only seek medical care when afflicted by disease or injury; therefore, they tend to receive just the treatment which is required at the time. Seldom is time in clinical settings allocated to preventive measures beyond brief admonitions, when appropriate, to watch one's diet, exercise more, and quit smoking.

Strategy 4.1.1

The academic health centers and other institutions training health professionals should survey their health professions programs and report on the following efforts in health professions education:

1) Emphasis on prevention in health professions education,
2) Curriculum development in the areas of community health, public health, epidemiology, population-based medicine, working in multidisciplinary teams, and cultural competency,
3) Methods of evaluating or testing competency of health professionals in these areas, and
4) Increasing clinic and community-based education sites to the degree practicable.

Reports should be submitted to the Statewide Health Coordinating Council by the following institutions:

1) Academic health centers
2) Community colleges
3) Technical colleges
4) Health Professions Education Advisory Committee
5) Other institutions training health professionals

Report and recommendations due to the Statewide Health Coordinating Council by October 1999.

Objective 4.2 Build the competencies of the public health workforce in the areas of core public health functions.

Background

Public Health Education

Although medical practitioners are used in both private health care services and public health, both roles require different responsibilities and competencies. Responsibilities and functions of public health include assessing community health needs, developing policies and plans to address these needs, preventing epidemics and the spread of disease, protecting against environmental hazards, preventing injuries, promoting healthy behaviors and mental health, responding to disasters, and assuring the quality and accessibility of both public and private health services.[15] These competencies and skills of public heath are summarized in the core functions of public health, that is, *assessment*, *policy development*, and *assurance.*[16] It has been estimated that the number of workers in public health with specialized graduate training in public health is less than 1 percent of that workforce.[17] This demonstrates the immediate need for a greater emphasis on the core functions of public health to be provided through the academic health curriculums of the state.

In 1995 the Texas Center for Health Policy Studies surveyed state public health leaders regarding training needs. These leaders were from three primary groups: 1) state officials, 2) local health directors, and 3) deputies and senior management staff at state and local agencies. Their responses to the study's survey identified management/leadership as the most important training need. Some of the barriers to leadership development named were 1) resource constraints, 2) social attitudes, 3) economic interests, and 4) conflicting social goals. To improve the public health infrastructure in Texas, ongoing training in leadership competencies and experience is a strategy that should be provided for public health leaders and managers.[18]

With the aim in mind of updating the health care workforce, especially in the area of public health, the 75th Texas Legislature passed House Concurrent Resolution 64 directing the University of Texas health science centers, the Texas Tech University Health Science Center, the Texas A&M University Medical Program, the University of North Texas Health Science Center at Fort Worth, the Baylor

College of Medicine, the University of Texas School of Public Health at Houston, and the Texas A&M University School of Rural Public Health to:

1) encourage their students to become partners in the health of individual Texans and Texas communities;
2) pursue and develop interdisciplinary curricula and interdisciplinary approaches to health care;
3) address long-term improvements in the health safety net of Texas;
4) pursue and develop technology that supports training opportunities for health professionals across Texas;
5) encourage more graduate and undergraduate medical education opportunities in community-based programs that incorporate a focus on public health; and
6) pursue methods to ensure that all public health students obtain practical experience outside of the classroom.

The Statewide Health Coordinating Council recommends that this mandate be expanded to include an emphasis on prevention strategies by all health professions.

Strategy 4.2.1

The University of North Texas Health Science Center, the University of Texas School of Public Health, the Texas A&M School of Rural Public Health, other institutions offering degrees and/or residencies in public health, and the Texas Department of Health work collaboratively to enhance the education and training of the public health workforce to:

1) develop and deliver programs and curriculums to develop the skills and competencies of the public health workforce;
2) improve the public health infrastructure in Texas through training for public health practitioners; and
3) expand distance learning technologies for the purposes of providing greater access to educational opportunities to members of the public health workforce.

Report and recommendations due to the Statewide Health Coordinating Council in November 1999.

Background

Health Promotion

Health promotion is an integral part of public health strategy. It is the means by which the public is informed and educated about healthier lifestyles and activities. In his seminal work, *Community Health Educator's Compendium of Knowledge*, Clair Turner stated:

> ...community health education, then, is a learning process through which people in a community inform or orient themselves for more intelligent health action, and a community health educator is a person who helps to organize and develop community interests, study, and action toward the solution of health problems.[19]

In a society that has open communications and a popular media, the public can be overwhelmed with conflicting sources of health information and advertising. Reliable sources of information concerning our health, and how to best maintain it, are essential elements of good preventive health strategy. Statistical research is generating clear and defensible evidence that health promotion and education can have positive impacts on lifestyle and behavior, and we are beginning to realize the potential breadth of opportunity of health education at all ages of the life cycle, and in all settings.[20]

Strategy 4.2.2

The Texas Department of Health's Health Education, Leadership and Promotion Council in collaboration with the Texas Society for Public Health Education and centers for health promotion research and development should:

1) develop a system for identifying the current competencies and future public health education/promotion workforce needs;
2) provide learning opportunities for those interested in becoming a Certified Health Education Specialist (CHES);
3) promote competency in the health education workforce by encouraging the health care industry to prefer CHES as a job qualification;
4) provide continuing education to all those who practice health promotion through continuing education contact hours for conferences, seminars, workshops, distance learning and self-

study opportunities that meet national competencies and responsibilities for health educators;
5) develop a system for recognizing quality initiatives in health promotion/ education; and
6) prepare culturally competent materials and programs for specific populations.

Report and recommendations due to the Statewide Health Coordinating Council in November 1999.

Objective 4.3 Create incentive systems to encourage prevention activities.

Background

Incentives

In recent years, economic pressures from rising health care costs have caused businesses and individuals to seek new ways to reduce health costs. Many large companies have begun strategies to lower such costs by encouraging employees to participate in wellness programs such as smoking-cessation clinics, exercise programs, nutrition clinics, health risk appraisals, and screenings for high blood pressure, diabetes, and high cholesterol.[21] Prevention provides a double benefit to employers by reducing health care costs as well as lost productivity due to employee sick time. These companies have also contracted with health care providers who are more competitive in providing quality health care at lower costs.

Health maintenance organizations have historically emphasized prevention and have developed systems to measure performance and improve service quality.[22] These systems can also include strategies such as screening for breast and prostate cancer, cholesterol checks, dental and eye exams, Papanicolaou smears, periodic physical exams, health and nutrition counseling, and medication reviews. Employers can obtain data on rates of various prevention activities from the National Committee for Quality Assurance through the Health Plan Employer Data and Information Set (HEDIS). Some of the HEDIS reporting set measures under the criteria of Effectiveness of Care include:

- Advising smokers to quit (in Member Satisfaction Survey)
- Flu shots for older adults

- Cervical cancer screening
- Breast cancer screening
- Childhood immunization status
- Adolescent immunization status
- Prenatal care in the first trimester
- Checkups after delivery
- Beta blocker treatment after a heart attack
- Treating children's ear infections
- Follow-up after hospitalization for mental illness
- Eye exams for people with diabetes[23]

Many health insurance companies and managed care organizations have accepted the necessity of promoting prevention programs to be competitive, but such measures are certainly not universal. In the *1997-1998 State Health Plan*, the Statewide Health Coordinating Council said the following about incentives being used by managed care organizations:

> To encourage prevention, financial incentives and/or regulatory requirements can be built into managed care agreements to encourage managed care organizations, (MCOs) practice of preventive care. For instance, financial incentives might be placed in managed care contracts to reward MCOs that meet specific goals. Such goals may include the number of mammographies or prostate cancer screenings performed per at-risk enrollee. Pediatric providers might be required to meet certain immunization goals or lose public funding. It is clear that public entities can require strong preventive measures in their contracts with MCOs in order to ensure preventive care for Medicaid eligibles.
>
> Including strong preventive health requirements in contracts between private payers and MCOs is a more complicated matter. Most large companies are self-insured, and federal law (ERISA) generally prevents states from regulating their health plans. Changes on the federal level would be required before Texas could require minimal preventive measures in managed care ERISA contracts.[24]

While incentives have encouraged many providers to utilize prevention strategies in their clinics, the primary medical paradigm of today still focuses on treatment. To change that paradigm, the academic health centers that train the doctors, nurses and health professionals of tomorrow must instill the need for a focus on prevention and health education in their students. A curriculum that

has this focus should emphasize community health, public health, epidemiology, population-based medicine, and working in multidisciplinary teams.

Strategy 4.3.1

The Texas Department of Health, the Texas Department of Insurance, representatives of the health care industry, and health care purchasers should establish incentives for prevention activities. Specifically, they should study and make joint recommendations on:

1) establishing or expanding incentives for health professionals to provide more preventive services; and
2) establishing or expanding incentives for consumers to follow through with preventive activities.

Report and recommendations due to the Statewide Health Coordinating Council in October 1999.

Objective 4.4 Develop a comprehensive approach to education of children in grades K-12 to encourage healthy lifestyle choices.

Background

K-12 Health Education

Providing education and incentives for health providers to expand efforts in prevention is just one part of the equation. The public must also become accultured to following healthier lifestyles and to seeking health providers that promote healthy lifestyles and wellness programs. Such acculturation can be actively promoted through the public schools; however, health education in Texas' public schools is grievously lacking. Until the mid-1980s, the state's essential elements of the public school curriculum required a semester of health education in both the middle school and high school. The curriculum was then changed and only six weeks of health education in high school science were left. In 1990 it was determined that there was not enough room in the science curriculum to include health, and so it was dropped.[25]

Currently the Texas Essential Knowledge and Skills, the curriculum framework for Texas school districts, requires only one-half unit of health education at the high school level. Health education can be voluntarily offered as part of the enrichment curriculum at the elementary and middle school levels. Seeking to bring health education back into the Texas public school core curriculum, the Texas Comprehensive School Health Initiative is a consortium of individuals from various organizations that are working together to enhance communication on efforts to promote a comprehensive school health program. Early education in preventive health would be a major influence in Texas children becoming healthier and more productive citizens. More children inspired toward careers in the health professions could be an added benefit.

Already the health treatment paradigm is changing, albeit incrementally. Economic pressures have begun the movement, but further measures are necessary to change people's attitudes. This is where educational changes are needed -- changes to the medical curriculum and changes to the public school curriculum.

Strategy 4.4.1

The Texas Education Agency, the Texas Department of Health, and the Texas Comprehensive School Health Initiative Consortium should investigate and recommend strategies for implementation of a model curriculum of health education for K-12.

Report and recommendations due to the Statewide Health Coordinating Council in November 1999.

Goal 5:	Reduce disparity in health status among all population groups and enhance their access to quality health care by developing a diverse and culturally competent workforce.

Objective 5.1 Develop a diverse and culturally competent workforce.

Background

Given the projected increases in the aging and the increasing racial/ethnic diversity the state will experience over the next 30 years, Texas' legislators and policymakers will face profound challenges on a number of social and economic dimensions. Adequacy of services in the state's health and human services arena will be a major area of focus and attention. Many factors, including socioeconomic status and level of education, contribute to disparities in health status in population groups. The Statewide Health Coordinating Council is focusing its attention on health care providers and their abilities to effect and bring about changes in the health status of these populations.

In their 1995 report to the legislature, the Texas Department of Health and the Texas Higher Education Coordinating Board identified the health professions workforce as the most critical factor affecting the state's health care system.[26] While Texas' physician workforce studies indicate that the state has a minimally adequate number of primary care physicians based on national benchmarks, the state reports and a 1997 report by the Council on Graduate Medical Education cite the maldistribution of health professionals as the ongoing issue in health care.[27] Texas does not have an adequate number of health professionals practicing in inner cities, along the Texas/Mexico border, and in rural areas -- areas that also have rapidly growing aging and racially and ethnically diverse populations.[28] These growing populations have significantly different patterns of disease and health care needs.

Minorities in the Health Care Workforce

The Council on Graduate Medical Education's latest report published in May 1998 and entitled "Minorities in Medicine," contends that:

> ...these projected demographics call for two parallel responses: enlisting greater numbers of minority physicians into the workforce; and training all physicians to become culturally competent to care for all populations.[29]

Minorities are underrepresented at all levels of medicine. Between 1996 and 1997, there was a 7 percent drop in underrepresented minorities (Blacks, Hispanics, and Native Americans).[30] Research has indicated that health professionals from racial and ethnic minority groups are more likely to practice in areas where there is a shortage of health professionals and to care for minority, poor, underinsured, and uninsured persons.[31]

Jordan J. Cohen, president of the Association of American Medical Colleges (AAMC) in his 1996 presidential address cited the following reasons why the medical and other health professions' racial and ethnic makeup should reflect that of the society. First, he feels that it is simply a matter of achieving justice and equity. Next, it has proven to be a viable solution to improving access to the underserved. Third is the ability of the workforce to deliver culturally competent care. Finally, greater inclusion of minorities in the workforce will help set research agendas that address health problems that are disproportionately evident in certain racial/ethnic groups.[32] In 1991 the AAMC established the *Project 3000 by 2000*. This initiative works through minority-focused community partnerships, academic medical centers, and K-12 school systems and colleges to recruit minorities into the medical profession. Their goal is to recruit and train 3,000 minority physicians by the year 2000.

In 1995 the Office of Minority Health at the Texas Department of Health called for an increase in the numbers of minorities in the health professions.[33] The Center for Rural Health Initiatives recommended that health policymakers develop concrete actions to attract people from rural communities into the medical and health professions also.[34]

This call for action has been echoed in reports produced by the Texas Department of Health with the Texas Higher Education Coordinating Board in 1995,[35] the Texas Medical Association in 1997, and the East Texas Area Health Network in 1998.[36]

The 1997 Hopwood vs. The State of Texas decision, which precludes the use of race or ethnicity as factors in admission considerations, requires creative approaches in attracting and building a culturally diverse workforce. Texas A&M University and the University of Texas System have made changes to their admissions policies and procedures in an effort to maintain or increase minority enrollment.

Texas needs a diverse and culturally competent workforce. To that end, the Statewide Health Coordinating Council proposes the following strategy to investigate ways to address disparity in minority health status and the recruitment and retention of minority health professionals.

Strategy 5.1.1

The Statewide Health Coordinating Council appoints an ad hoc committee to address the following racial/ethnic health issues and their relationship to health workforce education, planning, and practice. The committee should:

1) identify socioeconomic, educational, and cultural barriers to accessing health care;
2) forecast minority health needs;
3) develop goals and strategies to increase recruitment and retention of minorities in health care professions;
4) propose standards for culturally competent health care practice and practitioners; and
5) study and identify strategies that will reduce the disparities in minority health.

This ad hoc committee should be led by two Statewide Health Coordinating Council members and draw representation from:

1) Area health education centers
2) Texas Department of Health, Centers for Minority Health and Cultural Competency
3) Texas Department of Health, the Office of Border Health
4) Center for Rural Health Initiatives
5) Minority special interest groups, including health professionals and consumers
6) Admissions committees of health professions schools.

Findings to be presented as a report to the Statewide Health Coordinating Council by January 2000.

Objective 5.2 Develop a workforce equipped to meet the needs of Texas' aging populations and the population of persons with disabilities.

Background

Texas is aging. Persons age 85 and older are the fastest growing age group in the state. Despite the current rapid growth, Texas currently has a window of opportunity to prepare for the dramatic future growth of older Texans as the baby boom generation begins turning 65 around the year 2010.

The number of Texan's age 65 and over is expected to constitute 17 percent of the state's population by the year 2030.[37] In 1995 nearly one-third of the population over 75 lived in nonmetropolitan counties and 28 percent of those over age 65 live in rural areas.[38] The maldistribution of the health care workforce in Texas coupled with the health care needs of the aging population and the population of persons with disabilities constitute a serious health care workforce issue.

As people age, their health status is the product of a number of factors. Physiological aging may lead to a degeneration of the body as a lifetime accumulation of health behaviors exerts its influence. At the same time, external factors such as housing conditions and social cohesion or isolation influence the quality of life and wellness, and could make the elderly more susceptible to psychological problems like depression and self-neglect.[39]

The physiological process that we currently recognize as aging is characterized by decreases in physical activity, increased incidence of disease, and gradual degeneration of cognitive, neurological, psychomotor, and circulatory functions.

Some other measures of how frequently diseases and debility occur in the aging population include:

- Arthritis, a term used to describe over 100 different types of inflammatory and degenerative conditions that damage the joints, is the most common self-reported chronic condition among women. It is the number one cause of disability in America, limiting everyday

activities such as dressing, climbing stairs, and getting in and out of bed, for about seven million people.[40]

- In Texas more than 265,000 people have Alzheimer's Disease; one in eight of those is over 65, and 55 percent of Texans over the age of 85 are afflicted with Alzheimer's disease or a related dementia.[41]
- Although aging Texans as a group have a relatively low disability rate as compared to Florida, California and New York, roughly 30 percent of the state's aging population have functional limitations in more than three activities of daily living such as bathing, dressing, or getting in and out of bed.[42]
- Falls are the leading cause of nonfatal injuries and unintentional injury deaths in older persons in the United States.[43] Approximately 30 percent of all community-dwelling elderly age 65+ fall each year with an estimated three to five percent of these falls resulting in fractures.[44] In Texas there were 836 hospital discharges per 100,000 population in 1995 due to hip fractures in the 65+ population.
- The prevalence of diabetes in Texas appears to be much higher in older age groups. In 1995 while only about 14 percent of the adult population was age 65 and older, 25 percent of the Behavioral Risk Factors Surveillance System respondents who stated that they were diabetics were age 65 and older. Over half of the self-identified diabetics were age 55 and older.[45]

Rowe and Kahn in their book *Successful Aging*, report that the physiological process of aging can be slowed by 1) avoidance of disease and disability (prevention); 2) main-taining mental and physical function (lifestyle); and 3) continuing engagement with life (social contact and productivity).[46]

As with any special needs group, geriatric patients often prefer and are best served by professionals who are trained and experienced in meeting their unique health care needs. In Texas some of the health professionals with geriatric or gerontology certifications include:

Table 6-3: Texas Practitioners with a Specialization in Geriatrics

Profession	Primary / Secondary in Geriatrics
Physicians, as of 4/97 *	30 / 60
Advanced Practice Nurses **	139
Physical Therapists ***	8

* Health Professions Resource Center, Bureau of State Health Data and Policy Analysis, Texas Department of Health, February 24, 1998.
** Texas Board of Nurse Examiners, February 25, 1998.
*** American Physical Therapy Association, as of 1998.

These numbers represent only those certified in the few categories of health professions that have certifications in geriatrics and do not include many more who have developed the skills and practices in caring for the elderly. Nevertheless, these numbers compared with the aging population of the baby boom generation suggest that there is a great and growing need in Texas for health care practitioners who specialize in geriatric needs and care.

Those practitioners will need to have skills and competencies to help and guide their patients in making some very serious medical decisions. Many of today's patients are demanding more information and involvement in their health care choices. This means that health care providers must be trained to work in partnership with their patients; be prepared to advise and present treatment alternatives; and have a thorough understanding of the patient's legal rights as they relate to advanced directives, living wills, guardianship choices, and life-sustainment options.

Strategy 5.2.1

The Statewide Health Coordinating Council charges the Texas Department of Aging's Aging Policy Council and the Texas Department of Health to study the following aging population health issues and their relationship to health workforce education, planning and practice. The Aging Policy Council should:

- identify the health needs of an aging population,
- forecast health professionals/specialties that are needed to fulfill the health care needs of an aging population, and

- study and recommend health care policies and practices that enable individuals to age successfully.

Report and recommendations due to the Statewide Health Coordinating Council October 1999.

Strategy 5.2.2

The Statewide Health Coordinating Council charges the Texas Rehabilitation Commission to investigate the special health care needs of persons with disabilities, especially those in underserved areas, and make recommendations on the types of health professionals/specialists that are necessary to meet the needs of persons with disabilities.

Report and recommendations due to the Statewide Health Coordinating Council October 1999.

Goal 6:	Create a health workforce that works with communities and in partnership with federal and state governments to have the greatest positive impact on the health of citizens.

Objective 6.1 Design systems in which local communities are empowered to plan and direct interventions that have the greatest positive impact on the health of citizens.

Background

Community Health

The concept of community health has been evolving for more than a decade in response to the complex health, social and environmental issues that confront communities. For centuries, health has been viewed by societies as a valued condition to be protected.[47] Particularly in the 20th century, health status has been dramatically improved through public health. Also during this century, scientific and medical discoveries have permitted rapid advances in medical care. In recent years, however, the limits of medical service delivery have become increasingly apparent and the concept of communities creating health has emerged.

In 1985 in Toronto, Canada, participants in the "Beyond Health Care Conference" developed an innovative idea of community health promotion that was quickly adopted by the World Health Organization's (WHO) European office. In a little more than 10 years, with WHO and other support, this simple innovation has become an international movement.[48] The notion of a "healthy community" is based on the assumption that local structures and policies can have a profound effect on the physical and mental well-being of people in communities. Health in this context is defined broadly to include the full range of quality-of-life issues. According to the World Health Organization, a "healthy city or community" is working to become clean and safe with a physical environment and ecosystem that is sustainable.[49]

When a community undertakes the process of becoming healthier, a reorientation occurs, linking

public, private, and nonprofit sectors to address the underlying causes of poor health.[50] A healthy community strives to provide a thriving economy, opportunities for individual and industrial growth, adequate provision for the public health/medical care, and other essential needs of its population. In addition, a healthy community demonstrates an element *of interconnectedness.* Participants in the process represent the gamut of interests and roles that make a community work. The single defining feature is that its citizens, in all their various roles, have joined forces to pursue positive change.

In 1894 Theodore Roosevelt founded the National Civic League with the vision of involving citizens in the process of democracy. With this same profound faith in the power of cooperative problem-solving, community health initiatives help individuals, groups and communities work together at the local level to break down barriers of distrust and replace them with bridges of understanding. A healthy community demonstrates how people and institutions can collectively decide what needs are most pressing and how to meet them.[51]

The process of building a healthy community comes from community organization and development theory. Specific tools used include conducting community assessments such as Assessment Protocol for Excellence in Public Health (APEX) and the Planned Approach to Community Health (PATCH), mapping assets/needs, stakeholder analysis, civic journalism, facilitation, developing a plan to improve selected aspects of community health and benchmarking.[52]

Many national organizations, such as the National Civic League, HealthCare Forum, United Way of America, American Public Health Association, Washington Business Group on Health, and the American Hospital Association promote community health. Through a partnership of national, state and local interests, we can restore our communities' faith in their ability to effect real change, and our citizens, on every block in every neighborhood, will realize they have within themselves the power and ideas to make life better for themselves and others.

Strategy 6.1.1.

The Statewide Health Coordinating Council establishes an ad hoc committee to work in partnership with the Texas Department of Health and other state and community-based agencies and health care

delivery partners to develop a model for community health practice that defines the health professional's role as a resource and facilitator in local health.

Table 6-4: Model Characteristics of a Healthy City

A healthy city should strive to provide the following:

- A clean, safe physical environment of high quality (including quality housing);
- An ecosystem that is stable and sustainable;
- A strong, mutually supportive and non-exploitative community;
- A high degree of participation and control by the public over the decisions affecting their lives, health and well-being;
- The meeting of basic needs (for food, shelter, income, safety and work) for all the city's people;
- Access to a wide variety of experiences and resources, with the chance for a wide variety of contact, interaction, and communication;
- A diverse, vital and innovative city economy;
- The encouragement of connectedness with the past, and the cultural and biological heritage of city dwellers with other groups and individuals;
- An optimal level of appropriate public health and sick care services accessible to all, and
- High health status (high levels of positive health and low levels of disease)

Source: Promoting Health in the Urban Context - World Health Organization - WHO Healthy Cities Papers No. 1, FADL Publishers, Copenhagen, 1986.

This model for enhancing the partnership between community based public health and healthcare providers should include:

1) investigation of the root causes of disease at the community level;
2) innovative ways for sharing responsibility and authority for the community's use of resources;
3) initiatives to develop local leadership;
4) education of community based lay care givers; and
5) methods to enhance the commitment and capacity of state agencies to participate/ endorse/fund community activities.

Membership on this committee should include two Statewide Health Coordinating Council members and a representative of:

1) Texas Department of Health
2) Texas Department of Mental Health and Mental Retardation
3) Texas Hospital Association
4) Texas Association of Health Plans
5) Texas Agricultural Extension Agency
6) Texas Medical Association
7) Individuals who represent local interests/local participation/ consumer groups (such as: Texas Association of Counties, Texas Association of County Judges, Councils of Government, Texas Association of Business and Chambers of Commerce, Texas Association of Community Health Centers, Rural Community Health System Advisory Board, local health care professionals)

Progress to be presented as a report to the Statewide Health Coordinating Council by November 1999.

Objective 6.2 Develop the skill level of health professionals in working with communities.

Background

House Concurrent Resolution 64

As a model for partnership, the healthy communities movement requires full participation of health care providers. As mentioned earlier, House Concurrent Resolution (HCR) 64, which was passed in the 75th session of the Texas Legislature, recognized the importance for health practitioners having a firm grounding in the principles of community health. The resolution affirmed that new techniques such as community development are needed to develop effective health care systems for the future.

There is a need to pursue new insights and innovative solutions to health problems,

> and a new paradigm for the delivery of health care must be forged, in which all health care providers view themselves as co-workers along a continuum from from individual patient care to population-based intervention.[53]

The legislation also cites the importance of health professionals having the most innovative and up-to-date training when making decisions that affect the health of individuals and communities. Specific recommendations in the legislation included:

- to encourage students to become partners in the health of individual Texans and Texas communities;
- to pursue and develop interdisciplinary curricula and interdisciplinary approaches to health care;
- to encourage more graduate and undergraduate medical education opportunities in community-based programs that incorporate a focus on public health; and
- to pursue methods to ensure that all public health students obtain practical experience outside of the classroom.

The principles of community development provide a practical context for health care professionals to apply the science of public health and medicine in partnership with the community to have the greatest impact on improving health status and quality of life.

Strategy 6.2.1

The Statewide Health Coordinating Council establishes an ad hoc committee to work in partnership with interested parties to develop and test curricula to enhance the skills of health professionals for working more effectively with communities.

This committee will do the following:

1) identify partners to research and develop curricula and delivery methods;
2) pilot and test curricula;
3) evaluate outcomes; and
4) develop recommendations for adoption of the curricula in academic and/or continuing education settings.

Membership on this committee should include two Statewide Health Coordinating Council members and a representative of:

1) The Texas Department of Health
2) Interested universities
3) Individuals representing communities
4) Area health education centers

Progress to be presented as a report to the Statewide Health Coordinating Council by November 1999.

Goal 7:	Develop the health care partnership between consumers and health care professionals through increased access to health care information.

Objective 7.1 Enable consumers to make better health care decisions.

Background

The traditional relationship between consumers and providers has not generally expected patients to exercise their responsibilities as decision makers in treatment. At the same time, the education of health care professionals has not prepared them to consider their patients as part of the health care team. Changing expectations on the part of health care consumers and an emphasis on the individual's responsibility for managing his or her own health are changing the perceptions of what the provider/patient relationship should be.[54]

For consumers to become partners with their providers, they must be educated about their rights and responsibilities in an evolving health care system. Consumers will need to receive accurate, easily understood information about their health plans, professionals, and facilities if they are to make responsible decisions about their health care.[55]

Health care professionals in this relationship would be expected to modify their thinking when it comes to patients' rights and responsibilities. Health care professionals must also be educated and oriented toward including the patient as part of the health care team. This will become more important as people demand more information concerning the cost of their care, treatment options, and counseling on the use of advanced directives.

The Statewide Health Coordinating Council feels that consumers should be provided with sufficient information if they are to assume greater responsibility for their health care decisions.

Strategy 7.1.1

Statewide Health Coordinating Council appoints an ad hoc committee to develop guidelines,

principles, and standards for a consumer-oriented health care partnership. This committee should:

1) survey other states' consumer information systems;
2) investigate what kinds of information consumers should have access to in order to make informed health care decisions;
3) explore and make recommendations on user-friendly methods for disseminating consumer information; and
4) assess current initiatives and make recommendations for needed action.

This committee should include two members of the Statewide Health Coordinating Council and representatives from:

1) Health Care Information Council
2) Texas Department of Insurance/Office of Public Insurance
3) Health care industry
4) Health Professions Council
5) Citizen advocacy groups
6) Others as appropriate

Report and recommendations will be due to the Statewide Health Coordinating Council by January 2000.

Notes

1. "Director's Report," Office of Health Care Information. Office of the Commissioner of Insurance. State of Wisconsin. Summer 1996.

2. Wing, P. and E.S. Salsberg. *Data Systems to Support Health Personnel Planning and Policy Making. The New York State Department of Health*. October 1992.

3. Kany, J.C., and Janes, S.D., "Improving Public Policy for Regulating Maine's Health Professionals." A Report to the Governor and the Maine Legislature prepared for Medical Care Development, Inc. Maine Health Professions Regulation Project. October 1997.

4. "Physician Distribution and Health Care Challenges in Rural and Inner-City Areas," 10th Report Council on Graduate Medical Education, U.S. Department of Health and Human Services, Public Health Service, Health Resources and Services Administration. February 1998.

5. Ibid.

6. "America's Health: Seeking Solutions for the 21st Century." The Scott and White Assembly, February 19-22, 1997, sponsored by Scott and White Memorial Hospital and Scott, Sherwood and Brindley Foundation, and the LBJ School of Public Affairs.

7. "Telepractice and Professional Licensing: A Guide for Legislators," The Council on Licensure, Enforcement and Regulation.

8. "Physician Distribution and Health Care Challenges in Rural and Inner-City Areas," 10th Report Council on Graduate Medical Education, U.S. Department of Health and Human Services, Public Health Service, Health Resources and Services Administration. February 1998. p. 24.

9. Dakins, Deborah, and Ellie Jones, "Cream of the Crop: 10 Outstanding Telemedicine Programs," *Telemedicine and Telehealth Networks,* December 1996.

10. "Texas Telemedicine Strategic Planning Project: Draft Preliminary Report." Cosponsored by the Center for Rural Health Initiatives and the Texas Telehealth/Education Consortium. June 1997.

11. "Report of the 1997 Texas Telemedicine Panel Sessions," cosponsored by the Texas TeleHealth/Education Consortium and the Texas Center for Rural Health Initiatives with funding provided by the Texas Telecommunications Infrastructure Fund. March 1998.

12. "Telepractice and Professional Licensing: A Guide for Legislators," the Council on Licensure,

Enforcement and Regulation.

13. "Physician Distribution and Health Care Challenges in Rural and Inner-City Areas," 10th Report Council on Graduate Medical Education, U.S. Department of Health and Human Services, Public Health Service, Health Resources and Services Administration. February 1998.

14. Institute of Medicine, *The Future of Public Health*, Washington, D.C: National Academy Press, 1988.

15. Center for Health Policy Studies, *The Professional Public Health Workforce in Texas,* University of Texas Houston Health Science Center, School of Public Health, 1996.

16. Institute of Medicine, op cit.

17. Center for Health Policy Studies, op cit.

18. Ibid.

19. Turner, Clair, *Community Health Educator's Compendium of Knowledge,* St. Louis: C.V. Mosby Co., 1951.

20. Lazes, Peter M., Ph.D., *The Handbook of Health Education,* 2nd Ed., Rockville, MD: Aspen Publishers, 1987.

21. Schiff, Lisa, "Encouraging Health with Whatever It Takes," *Business and Health*, April, 1998, pp. 97-8.

22. National Committee for Quality Assurance, website, http://www.ncqa.org/news/hedismeas.htm, 1998.

23. Statewide Health Coordinating Council, *Texas State Health Plan: 1997-1998 Update*, 1996.

24. Ibid.

25. Fleming, Thomas, Texas Education Agency, electronic mail correspondence, June 17, 1998.

26. "Physician Workforce Strategy for Texas," A Report for the Subcommittees on Health and Human Services and Education of the House Appropriations Committee. February 1995.

27. "Physician Distribution and Health Care Challenges in Rural and Inner-City Areas," 10th Report Council on Graduate Medical Education. U.S. Department of Health and Human Services, Public Health Service, Health Resources and Services Administration. February 1998.

28. Health Professions Resource Center. Health Professions Shortage Areas. Texas Department of Health.

29. "Minorities in Medicine," Council on Graduate Medical Education Twelfth Report, U. S. Department of Health and Human Services, Public Health Service, Health Resources and Services Administration, May, 1988, p.xii.

30. Ibid.

31. Ibid.

32. Cohan, J. J. "Finishing the Bridge to Diversity," President's Address. Association of American Medical Colleges. November 8, 1996. http://www.aamc.org.

33. "Minority Health in Texas: A Report to the 74th Legislature," Office of Minority Health. Texas Department of Health. 1995.

34. "Rural Health In Texas: A Report to the Governor and the 75th Legislature," Center for Rural Health Initiatives. 1997.

35. *Primary Care Physician Education in Texas,* Report to the Subcommittee on Primary Care, Texas Medical Association, January 1997

36. East Texas A.H.E.C., "Summary Progress Report 1/98.SU76 PEOO238," 1998.

37. Murdock, S. H. *Texas Challenged: The Implications of Population Change for Public Service Demand in Texas,* 1996, College Station: Texas A&M.

38. Bureau of State Health Data and Policy Analysis, Texas Department of Health, Population Data System, 1998.

39. Texas Department on Aging, 1998, http://www.tdoa.state.tx.us/stats.htm.

40. Centers for Disease Control and Prevention (CDC), "Targeting the Debilitating Effects of Arthritis," briefing paper on the Arthritis Foundation web site, http://www.arthritis.org/advocate/bp/debilitating.shtml, February 1997.

41. Texas Council on Alzheimer's Disease, *Biennial Report,* 1996.

42. Texas Department on Aging, 1998, http://www.tdoa.state.tx.us/stats.htm.

43. U.S. Preventive Services Task Force, *Guide to Clinical Preventive Services,* 2nd edition, 1994.

44. Campbell A.J.,et al. " Risk Factors for Falls in a Community-based Study of People 70 Years and Older." *Journal of Gerontology*, 1989: 44: 4; M112-117.

45. Texas Department of Health, Texas Behavioral Risk Factor Surveillance System, unpublished data, 1998.

46. Rowe, J.W. and Kahn, R.L., *Successful Aging*, Random House: New York, 1998.

47. National Civic League. *The Healthy Communities Handbook*. (Denver, Colorado), 1993, p. 10.

48. WHO Healthy Cities Project: *A Guide to Assessing Healthy Cities*, WHO Healthy Cities Papers No. 3 (Copenhagen, FADL Publishers, 1988).

49. WHO Healthy Cities Project: *A Guide to Assessing Healthy Cities*, WHO Healthy Cities Papers No. 1 (Copenhagen, FADL Publishers, 1988).

50. United States Public Health Service, Department of Health , "Starting Points for a Healthy Community," 1995.

51. U.S. Health Corporation. "The Healthy Community Assessment Process," 1994.

52. National Civic League website: http://www.ncl.org/ncl/toolbox.htm.

53. House Concurrent Resolution 64. 75th Legislature of the State of Texas. Filed by Rep. Dianne Delisi.

54. Finocchio, L.J., C.M. Dower, et al., The Taskforce on Health Care Workforce Regulation, *Reforming Health Care Workforce Regulation: Policy Considerations for the 21st Century*. San Francisco, CA: Pew Health Professions Commission, December 1995.

55. "Consumer Bill of Rights and Responsibilities: Report to the President of the United States," President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry. PACCPQHCI website. http://www.hcqualitycommission.gov/CBORR/consbill.htm, November 1997.